HealthPOWER!

Prevention News

Veterans Health Administration March 2005

What's Inside:

What's on NCP's Calendar

Calendar of Events

Past

* Naval Environmental Health Conference—Woodward Lecture, February 14, 2005
* American College of Preventive Medicine, February 16-20, 2005
* HSR&D Meeting, Baltimore, MD, February 16-18, 2005
* Employee Wellness Advisory Conference Call, February 22, 2005
* Preventive Medicine Field Advisory Conference Call, February 24, 2005
* USPSTF Meeting, March 17-18, 2005

Future

* National Public Health Week, April 4-10, 2005 (http://vaww.nchpdp.med.va.gov/MPT_2005_04.asp)
* PCS Strategic Planning Committee, April (7, 14, 21, 28) May (5, 12, 19, 26) 2005
* Medical/Surgical Strategic Planning Group, April (7, 14, 21, 28) May (5, 12, 19, 26) 2005
* National *MOVEmployee!* Day, May 18, 2005

Prevention Topics

- April—Aging/National Public Health Week (April 4-10) (http://vaww.nchpdp.med.va.gov/MPT_2005_04.asp)
- May—Breast/Cervical Cancer (http://vaww.nchpdp.med.va.gov/MPT_2005_05.asp)
- June—Hepatitis (http://vaww.nchpdp.med.va.gov/MPT_2005_06.asp)

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NCP Mission Statement

The VA National Center for Health Promotion/Disease Prevention (NCP) is the central resource for "All Things Prevention," to include: prevention information, prevention education and training, prevention research, and prevention recommendations for the VHA. The Center facilitates the improvement and availability of prevention services in order to reduce illness, death, disability, and cost to society resulting from preventable diseases.

From the Director's Desk…

Steven J. Yevich, MD, MPH

The New Service Member

I was honored to present the Woodward Lecture on 14 FEB 05 at the 44th Annual Navy Occupational and Preventive Medicine Conference, sponsored by the Navy Environmental Health Center (NEHC), commanded by CAPT D.A. Hiland. This joint prevention conference is attended by approximately 1500 tri-service, Active/Guard/Reserve personnel interested in prevention, and is held in conjunction with the 10th Annual Independent Duty Corpsman Conference and the 6th Annual Combined Operational and Aeromedical Problems Course. The conference is one of very high caliber, and the hosts were most gracious, making this meeting first class.

The title of my speech was "*Prevention: Be Healthy BEFORE You're a Vet*", and it was a Lesson-Learned about the life cycle 99% of us veterans go through from active duty to retirement. I traced how all service members start out knowing the importance of prevention when on active duty…

> *"EVERYONE and Everything is PREVENTION in the military!! Prevent bullet wounds; prevent your rifle from rusting, prevent radar detection; prevent commo interception; prevent combat fatigue; prevent malaria, water and food borne illnesses; prevent sunburn, other heat and cold injuries. Jet lag; sleep/work cycles; injury prevention; protective gear like goggles, ear plugs, knee and ankles braces, counterbalanced helmets, ergonomically designed and placed controls, seats, windows, pedals, computer keyboards and monitors. "Everyone" in the US military knows about the threat and principles of protection from STDs; they know that tobacco is bad for one's health; they know that using illicit drugs or excessive use of alcohol is outright illegal and can result in poor health, and/or can cloud judgment and result in poor decisions that affect one's health..."*

…how all service members are taught to take personal responsibility for their own health:

> *"What happens if a service member fails to assume **personal responsibility** to protect his/her health by following prescribed preventive actions? There is punishment for service members who knowingly ignore health risks and incur bad health outcomes ("destruction of 'Gov't property'" -- even sunburn!). You don't meet height and weight or pass the PT test, you know that's the ticket to be drummed out! DUIs and drug possession result in very harsh punishments..."*

…plus how military Leadership assumes responsibility:

> *"And the responsibility for the health of subordinates is also put upon the successive layers of leadership. **Leadership Responsibility**! What happens if even squad level leaders ignore prescribed preventive measures and allow their troops to operate without risk minimization? Again, punitive retribution is defined for the Leadership who ignore, or who allow their subordinates to ignore, health risks."*

But then, something happens when service members leave the military. They enter the "Fatal Gap" – the time between leaving the service and the Senior Years, resulting in the all-important "Senior SAT scores" (see numerous previous editions of this newsletter for Fatal and SAT explanations). I noted that the actual number of combat-wounded vets tends to be very low compared to the number of vets, who use VA's healthcare system, who present with chronic disease resulting from potentially preventable behaviors. Something happens after vets leave the service (I call it *vet-morphing*), such that they ignore (or is it rebel against?) the prevention messages for the next several decades, until they show up at VA facilities with chronic disease pathologies irreversibly locked in. My warning to the conference attendees was to prepare for living healthy NOW, while they are still healthy, to instill a healthy mentality about health – and don't do it for the sake of military regulations, but for the sake of their health in the long run.

My messages were: live like you're going to be 100 years old; treat your health like an investment

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and start building your bank account now; take personal responsibility for your health, don't blame it on the government; minimize the Fatal Gap; and start working to maximize your "Senior SAT scores" now, while you're still healthy.

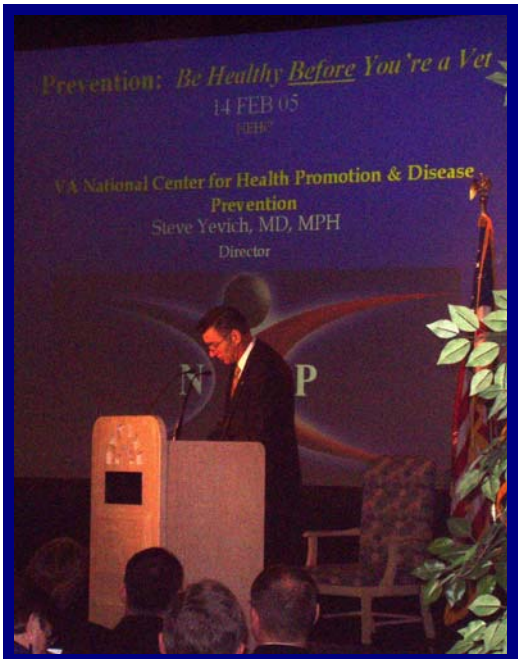
You know, it's different speaking to active duty service members versus retiree veterans. The mentality is different; the attitude is different; the perspective is different; the priorities are different; the vibe is different. This new generation experiencing deployments in the military has almost universally experienced the threat of death regardless of their job descriptions. No longer are the medical personnel, or the administrative people, or the truck drivers, or the gadget repairmen, or the doughnut makers, in a Safe Zone. The loss of the clearly demarcated Front Line means everyone is always a target for annihilation. Their priorities are much different from previous decades. The threat of being a random target for death was probably last seen in Vietnam, and even there, to a much more limited extent than what is being experienced in Iraq today.

I half expected that these new warriors would have a much more cynical perspective on health, knowing that their lives could be randomly ended at any random moment. But, the opposite was true. These new warriors KNOW the value of life and health, and my message hit home. They are enthusiastic; they believe in maximizing their quality of life and of sustaining their health. The unmistakable feedback I got was that returning service members know how short life can be, and therefore how important it is to keep healthy. They are cautious and they are smart about not taking unnecessary chances.

Now, all we have to do is make sure they have the tools to stay healthy, and that they don't fall in the Fatal Gap and forget about prevention when they leave the service! That's your and my jobs at VA – protect vets' health; prevent disease before it gains a toehold; keep them healthy.

Are YOU doing anything for prevention, or are you just firefighting?

yevich out



"Prevention: Be Healthy BEFORE you're a Vet"

Yevich receiving Woodward Lecture Award from CAPT D.A. Hiland and Master Chief Dana Goodwin

From the Chief of Staff…

Mary B. Burdick, PhD, RN

Preventive Medicine Resident: The National Center for Health Promotion and Disease Prevention (NCP) was delighted to have the first Preventive Medicine Resident from a VA funded residency program complete a two-month rotation in our office. Dr. Xu Wang came to us from Dr. Joyce Jones' Preventive Medicine residency program at the Murfreesboro, TN VAMC and Meharry Medical College. While here, Dr. Wang contributed substantially to the preparation of *MOVE!* materials and participated in other national prevention activities, under the supervision of Dr. Linda Kinsinger. Dr. Wang received a Certificate of Appreciation from NCP Director, Dr. Steven Yevich. NCP will be welcoming our second Preventive Medicine resident from the Murfreesboro VAMC/Meharry program in April.

Dr. Kinsinger, Dr. Wang and Dr. Burdick

Preventive Medicine Field Advisory Committee: The first Preventive Medicine Field Advisory Committee was held by conference call on February 24, 2005 from 2:00 – 4:00 p.m. EST. Dr. Steve Yevich, NCP Director, welcomed members and explained the focus: to serve as a forum to surface, discuss, and attempt to resolve field prevention issues; to provide direct feedback to NCP to take to VACO and national attention; to provide a "sanity check" for Prevention in the VA; to provide the forum through which VISN Preventive Medicine Leaders (the PM-FAC) take ownership/leadership of Prevention in VA. The Council reviewed a draft Charter, reviewed and discussed results of a VPML survey, presented by Sharon Hull, MD, MPH, and shared numerous ways to promote prevention. Dr. Kenneth Jones, MD, MPH, presented an update on the *MOVE!* Program. Dr. Yevich discussed the status of the Prevention Directive (will endorse .5 FTEE for facility Prevention Coordinator role, establish multi-disciplinary Prevention team, and eventually develop criteria for certification for trained PCs) and the PC Course (will not be held this year, but will be held in conjunction with Primary Care conference in FY 06, between November and February). Committee members have been asked to elect a FAC Chair and Chair Elect.

Obesity Article, ACPM: Obesity Prevalence Among Veterans at VA Medical Facilities, American Journal of Preventive Medicine 2005;28:291-94 (http://www.ajpm-online.net/issues/contents). The NCP recently completed a cross-sectional analysis of over 1.8 million veterans receiving outpatient care at 135 VA medical facilities in 2000. Measured weight, height, and demographic data were used to obtain age-adjusted prevalences of body mass index (BMI) categories, which were stratified by gender and examined by age and race/ethnicity. The analysis showed that, of 93,230 women veterans, 68.4% were at least overweight (BMI≥25 kg/m^2), with 37.4% classified as obese (BMI≥30), and 6.0% as class III obese (BMI≥40). Of 1,710,032 men veterans, 73.0% were at least overweight, with 32.9% classified as obese, and 3.3% as class III obese. Among women, obesity prevalence increased into the sixth and seventh decade of life before prevalence began to decline. Among men, prevalence was lowest for those aged <30 and >70 years. By race/ethnicity, Native American women (40.7%) and men (35.1%) had the highest prevalence of obesity, while Asian-American women (12.8%) and men (20.6%) had the lowest. Racial/ethnicity data, however, were not self-identified and were missing for nearly 43% of the population, thus data for Native Americans should be interpreted with caution. These finding support the need for a comprehensive approach for weight management, such as *MOVE!* (Managing Overweight/obesity for Veterans Everywhere) within VHA.

Flu briefing to Dr. Perlin: Several VA offices are working together to assure that the VA has adequate influenza vaccine and to plan specific procedures be prepared for next year's influenza season. Some of these include the Public Health Strategic Healthcare Group, Office of Infectious Diseases, Pharmacy Benefits Management and Office of Occupational Health and Safety. The group briefed Dr. Perlin on VA's current status March 29, 2005. Further activities to ensure an adequate vaccine supply will be coordinated by these offices.

Ask Dr. Linda...

Linda Kinsinger, MD, MPH
Assistant Director for Policy, Programs, Training and Education, VA NCP

Question: What are acceptable screening tests for colorectal cancer?

Answer: Acceptable screening strategies include: annual FOBT (3 cards with 2 windows each, done at home), flexible sigmoidoscopy done every 5 years, colonoscopy done every 10 years, or double-contrast barium enema every 5 years (not a preferred screening strategy but acceptable if done for other reasons).

Question: Can you clarify the recent news about the number of deaths from cancer and heart disease?

Answer: The latest information about number of deaths from cancer and heart disease came out just a few weeks ago from the American Cancer Society and made front-page headlines. But it got a little jumbled in the media.

Including **all ages**, heart disease continues to be the leading cause of death (356,000 deaths in women in 2002 vs. 268,500 deaths from cancer). However, for deaths in women (and men) **under age 85**, cancer is now the leading cause (for men and women combined, 476,000 deaths in people under 85 from cancer vs. 450,600 deaths from heart disease in 2002). (The paper in which these figures are published is free online at http://caonline.amcancersoc.org/cgi/reprint/55/1/10 and appear in *CA Cancer Journal for Clinicians*). The difference is that there are far more deaths from heart disease in the elderly (over age 80 or so, see Table 6). Cancer is the leading cause of death in women ages 40 to 79, but after that, heart disease deaths increase substantially.

We need to continue to work to prevent premature deaths from both causes!

Question: What are the implications for VA regarding recommendations for abdominal aortic aneurysm (AAA)?

Answer: The US Preventive Services Task Force recently announced its recommendations for screening for abdominal aortic aneurysm (AAA). It gave a grade B recommendation for one-time screening by ultrasonography in men age 65 to 75 who have ever smoked, a grade C recommendation (no recommendation for or against) in regard to men age 65 to 75 who have never smoked, and a grade D recommendation against screening for AAA in women (http://www.annals.org/content/vol142/issue3/).

This set of recommendations is a good example of how the USPSTF weighs the evidence about screening and makes its recommendations. Two considerations go into the letter grade of the recommendation: a judgment about the quality of the evidence and an estimation of the magnitude of net benefits (benefits minus harms). In the case of screening for AAA, the quality of the evidence, based on 4 randomized controlled trials of screening, was rated "good." The results were consistent across the 4 studies and the trials were well-designed and well-conducted and assessed effects on health outcomes. All studies found that the risk of death due to ruptured AAAs was decreased by about 43% in those who were screened and found to have large aneurysms (5.5 cm or larger). Ultrasonography is an accurate and safe test (when done in appropriate facilities). However, open surgical repair of AAAs has been shown to have an operative mortality of 4-6% with a 32% rate of important complications, so the balance between benefits and harms was considered "modest." Thus

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the letter grade for the population most at risk was a B (good quality of evidence; benefits somewhat greater than harms).

The major risk factors for AAA are age, male sex, and a history of ever smoking. Younger patients, women, and those who have never smoked are at much lower risk of aneurysms that are likely to rupture and lead to death. So they are far less likely to benefit from screening. Most women who die of ruptured AAAs are in their 80s, when they are likely to have other important health concerns, so screening would have less benefit. As always, recommendations about screening must be individualized to each patient's risk and likelihood to benefit.

The group that develops clinical practice guidelines for VA/DoD is evaluating these recommendations. Some guidance is likely to be coming out in the next few months. Rough calculations from the SHEP survey show that about 30% of the VA out-patient population are men in the 65 to 75 age range and, of those, about 80-85% have ever smoked, so the size of the population that might be eligible for the one-time screening is fairly large. Patients who would not be good operative candidates should not be screened. The challenge is addressing the logistical problem of screening a large number of men over the next few years. The VA has experience with this from a trial (ADAM) done in 16 VA facilities, in which over 126,000 men were screened (http://archinte.ama-assn.org/cgi/reprint/160/10/1425.pdf).

Cartoon courtesy of Cagle Cartoons, Inc.

Infectious Diseases Section

Kristy Straits-Tröster, PhD, ABPP

Now that spring is here and we are past peak influenza season, here are a few updates and points to keep in mind as the "flu season" winds down in the U.S.:

- Local influenza activity is the best guide for when to stop giving flu shots. Although the flu season appears to have peaked nationally, there are still new outbreaks being reported regionally.
- For international travelers, keep in mind that the number of new cases of influenza in Europe has peaked later than in the U.S. this year. Don't forget to check with the CDC regarding recommended vaccinations and other health recommendations for traveling to your destination at: http://www.cdc.gov/travel/
- Vaccination for pneumococcal pneumonia is still indicated once per lifetime for adults 65 years of age and older, and anyone over 2 years of age who has chronic health problems or any disease or treatment that lowers the body's resistance to infection. The pneumococcal polysaccharide vaccine (PPV) may be given at any time of the year, and pneumococcal vaccination rates continue to be monitored as a Performance Measure for VHA. Some adults may need a second dose of PPV if they were younger than age 65 when they received their first dose and more than 5 years have passed since that first dose, or if they have certain chronic conditions (e.g., chronic renal failure or nephrotic syndrome, functional or anatomic asplenia, immunosuppressive conditions such as HIV or certain malignancies, or taking long-term steroids or chemotherapy).

The Journal of Family Practice's new Immunization Supplement, "Vaccines Across the Life Span, 2005" is now available. To access the supplement online, go to: **http://www.jfponline.com/supplements/supp_0105.asp**

Scheduled for April 14, at noon ET, the CDC'S next "Current Issues in Immunization" Net Conference is designed to provide clinicians with up-to-date information on immunization. The one-hour program has two primary topics: (1) the new recommendations for meningococcal vaccine and (2) an influenza update.

The conference requires pre-registration, as space is limited. To register for the conference, go to: **http://www2.cdc.gov/nip/isd/ciinc**

MOVE! Update

Kenneth Jones, PhD
***MOVE!* Program Manager, VA NCP**

In the last edition of the newsletter, I credited VISN 8 with being one of several sites that have become early implementers of *MOVE!* The pictures on the right arrived just after the newsletter was published. Check out the photos of key staff members from VISN 8 who have been instrumental in *MOVE!* implementation.

The *MOVE!* team from Tampa, has an abstract that has been accepted for poster presentation at the VHA eHealth University (VEHU) at Opryland, May 23-26. Their abstract, "IT on the MOVE!," addresses the customized CPRS tools, clinical reminders to display the BMI on the CPRS cover sheet and a screening clinical reminder developed for *MOVE!* implementation as well as templates to support documentation of results of the *MOVE! 23* questionnaire, patient education, and patient goals. The reminder dialog assists the nurse/clinician to document the patient's readiness to begin a weight management program. We will tell more about their presentation after the event.

Also in VISN 8, *MOVEmployee!* is being promoted by a Competency Development for Leaders in the 21st Century project. This project recognizes the need to keep our VA workforce healthy and to serve as healthy lifestyle models for our patients.

There have been several new developments since the last newsletter. The www.move.med.va.gov website is up and running. MyHealth*e*Vet has also provided a link to the www.move.med.va.gov Internet site. While our VA Intranet site, vaww.move.med.va.gov, is focused on VA clinical staff, the new Internet site is patient-focused. The Internet site, either accessed directly or through MyHealth*e*Vet, enables patients to complete the *MOVE! 23* computerized questionnaire and obtain an individualized report. No personally identifiable information is requested by the Internet version of the *MOVE! 23*. The patient report contains a code number that will enable VA *MOVE!* clinical staff to access the patient's responses and generate the *MOVE!* clinical staff report. These innovations will allow for patients to complete the *MOVE! 23* from on or off-station in a fully secure manner.

NCP is working with Employee Education Services to develop online *MOVE!* training in preparation for the national implementation of *MOVE!* We are pursuing CME/CE for staff who complete the training.

On March 22nd, Tracey Bates, MPH, RD, LDN and I traveled to Washington, DC to present the *MOVE!* Program. We met with Ellen Bosley, MBA, RD, the new VHA Director of Food & Nutrition Services, and Tony Powell, Special Assistant, Office of the Under Secretary for Health who directs the food service for the Veterans Canteen Service. Following this meeting, *MOVE!* was the featured topic for the National Nurses Forum. Then, we presented *MOVE!* to the VACO Area Directors.

On Wednesday, March 30th, Tracey and Dr. Richard Harvey, NCP Assistant Director, Preventive Behavior, presented an overview of *MOVE!* and a demonstration of the *MOVE!* 23 to VISN 3 (New York/New Jersey) via video teleconference. They, along with staff Leila Kahwati, MD, MPH, *MOVE!* Medical Consultant, and Bryan Paynter, *MOVE!* Information Technology Specialist, fielded questions from VISN 3 staff. This early implementation call went well! NCP looks forward to VISN 3 joining VISNs 2,8 and 23 in launching VISN-wide MOVE programs.

Lastly, look for information about *MOVEmployee!* Health & Fitness Day, May 18th. VA medical facilities are asked to offer a Wellness Walk & Roll during the noon time hour. Employees of all fitness and ability levels can join together to move (walk or roll). For those employees who cannot leave their post or cannot be present due to shift schedules, a Prevention Pledge is available to accommodate involvement and commitment to healthy behavior. Additional health promotion activities are encouraged. To aid staff participation in this event, NCP has developed the following:

- Flyer to publicize the Wellness Walk & Roll as well as any other planned activities
- Certificates and stickers for those participating in the Wellness Walk & Roll
- Prevention Pledge template for employees who cannot participate in the sponsored activities, but will be active that day
- Prevention Pledge roster to record all those taking a pledge for prevention
- Sample press release template
- Sample invitation for local media to attend
- *MOVEmployee!* Health & Fitness Day talking points
- Handouts on healthy eating and physical activity

Pictures and written reports for the Wellness Walk & Roll will be collected from the field by NCP and featured in the **Health*POWER!* Prevention News as well as posted on the website.** A formal summary report will be forward to VHA leadership. Check with your Wellness Coordinator or the VA National Center for Health Promotion and Disease Prevention (919-383-7874) for more information.

MOVE! Program Implementation—VISN 8

VISN 8 Leadership Training Group who are developing a plan to implement *MOVEmployee!* in VISN Pictured: Front row—Gladys Navarro (San Juan); Mary Zaborsky (West Palm Beach); Bridget Kathleen Booth (Gainesville); Christi Rodriquez (Process Liaison) Back row—Barbara Parker (Content Liaison); Cristy Michelle Thomas (Lake City); Charlotte Gatlin (Tampa); Gerry Botko (Oakland Park/Miami)

Tampa VA Medical Center
Staff Training for the Formal Launch of *MOVE!*

MOVE! Success Stories

(This begins a series of personal stories detailing individual successes with *MOVE!)*
VA Medical Center, Murfreesboro, Tennessee
(Patient: Mr. Charles Baylis)

Weight Loss: **August 31, 2004—277 lbs**
February 1, 2005—241 lbs
Total Weight Loss: **36 pounds**

Q: Mr. Charles Baylis, how did you learn about the "*MOVE!*" weight loss program?

A: From my primary care physician.

Q: What made you decide to enroll into the program?

A: I already had the intention to lose weight and had started doing things to lose weight prior to enrolling into the *MOVE!* program (e. g., dieting). But later I was told it was not the right way to lose weight. *MOVE!* program was recommended.

Q: Did you have a dietitian/ nutritionist consult? If yes, do you feel you benefited from it and how?

A: I had dietitian consult and it was beneficial. Dietitian and I differed on how far down I should lose weight. She felt that my target was lower than what her target weight for me was.

Q: Could you briefly tell me about how you changed your eating habits?

A: I cut off sweets from my diet and exercised 'portion control' with respect to how much to eat at one time. Improve my choice of foods with low calorie diet.

Q: What kind of physical activity/activities did you do and how did you schedule these activities?

A: Do several exercises regularly at different times including stationary bike use, treadmills use, walking and measured my steps by use of pedometer, etc.

VA Medical Center, Murfreesboro, Tennessee
***MOVE!* Team with Mr. Baylis**
Pictured from left to right: Dr. Jones, Dr. Vorkpor, Dr. Moriarty, Ms. Martin, Mr. Baylis

Q: What are some benefits for participating in *MOVE!* program?

A: *MOVE!* is not restrictive and if you follow the guidelines included in the handouts, the desired outcome will be met.

Q: Any suggestions for possible change in the program?

A: My only suggestion is that when one completes the program, the person should continue to come for follow up for at least a year to make sure that the weight is not regained.

Q: What will you say to someone who wants to lose weight or is in similar situation like you were?

A: Enter the *MOVE!* program and follow the guidelines given including reading the handouts. You will lose the weight you want to lose.

Q: How would you compare participation in *MOVE!* to losing weight on your own?

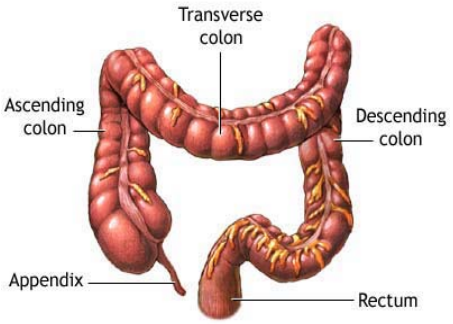
A: *MOVE!* is better because of the 'accountability factor' built in it that makes you wanting to lose weight before coming to be weighed at the clinic.

Q: How beneficial did you find the handouts you received from the *MOVE!* program?

A: The handouts are read by me as soon as they are given. I always refer to them when I need an answer to a question. They help me get the information I need.

Colorectal Cancer

Colorectal cancer – cancer of the colon or rectum – is the second leading cause of cancer-related deaths in the United States for both men and women combined. The disease surpasses both breast and prostate cancer in mortality, second only to lung cancer in numbers of cancer deaths.



Most colon and rectal cancers begin as small, noncancerous clumps of cells called polyps. Over time, some of these polyps become cancerous. Polyps may be small and produce few, if any, symptoms. That is why it is important to get regular screening tests to help prevent colorectal cancer.

Signs and Symptoms

Like many people with colorectal cancer, there may not be any symptoms in the early stages of the disease. When symptoms appear, they will likely vary, depending on the cancer's size and location in the large intestine. See your health care provider if any of the following signs and symptoms persist for more than a couple of weeks:

- A change in your bowel habits, including diarrhea or constipation or a change in the consistency of the stool.
- Narrow, pencil-thin stools.
- Rectal bleeding or blood in the stool on more than one occasion.
- Persistent abdominal discomfort, such as cramps, gas, or pain.
- A feeling that the bowel does not empty completely.
- Unexplained weight loss.

Blood in the stool may be a sign of cancer, but it can also indicate other conditions. Bright red blood noticed on bathroom tissue may come from hemorrhoids or minor tears in your anus. Normally, hemorrhoids do not bleed consistently over a period of weeks. If the bleeding is prolonged, talk to a health care professional.

In addition, certain foods such as beets or red licorice can turn your stools red. Iron supplements and some anti-diarrhea medications may make stools black. Still, it is best to have any sign of blood or change in the stool checked promptly by a health care professional.

Risk Factors

Colorectal cancer can occur at any age, and no one is too young to develop colorectal cancer. However, about 90 percent of people with the disease are older than 50. Factors other than age that place one at a higher risk include:

- Inflammatory intestinal conditions
- Family history
- Diet
- Sedentary lifestyle

The most effective risk reduction tool for colorectal cancer is undergoing routine colorectal screening tests. Screening tests can identify colorectal polyps that can be cancerous. When discovered through screening tests, these polyps can be removed – preventing colorectal cancer from ever occurring.

This is one of several educational handouts developed for this topic. For information about Colorectal Cancer (March Prevention Topic), visit the VA National Center for Health Promotion and Disease Prevention website www.VAprevention.com

Celiac Disease

Jennifer Tucker Patterson, MS, RD, CDE
Overton Brooks VA Medical Center, Shreveport, LA

What is celiac disease?

Celiac Disease (CD) is a digestive disease that damages the small intestine and interferes with absorption of nutrients from food. People who have celiac disease cannot tolerate a protein called gluten, which is found in wheat, rye, oats and barley. Nutrition related problems such as lactose intolerance, osteoporosis, iron deficiency anemia, folate deficiency, Vitamin B12 deficiency, constipation and diarrhea might result from malabsorption in the small intestines.

What are the symptoms and prevalence of celiac disease?

Gastrointestinal clinical manifestations may include diarrhea, weight loss, failure to grow resulting in short stature, vomiting, abdominal pain and distention. Recent research shows that CD is more prevalent than once thought—affecting 1 in 266 people worldwide. Misdiagnosis is common with a mean delay of correct diagnosis by eleven years. Occurring in ~5% of CD patients is a condition called Dermatitis Herpetiformis. This condition is characterized by an intense rash that occurs on the head, neck and extremities. If left untreated, CD patients have a 20 to 30 times increased chance of developing intestinal lymphoma. As an autoimmune disorder, it has been determined that 3 to 8% of patients with Type I diabetes may have CD. Patients can be either symptomatic or asymptomatic with the disease developing in both childhood or as an adult.

How is celiac disease diagnosed?

Diagnosis is determined through serologic testing while the patient is consuming a gluten-containing diet and a small intestine biopsy. The best available tests are the IgA antihuman tissue transglutaminase (TTG) and the IgA endomusial antibody immunofluorescence (EMA) tests.

What is the treatment?

Management of CD is a life-long gluten-free diet. Naturally occurring gluten-free foods include fresh meats, fish, poultry, nuts, seeds, eggs, legumes, milk, yogurt, cheese, fruits, vegetables and alternative grains. The majority of patients with CD are lactose intolerant, however this may dissipate once the gluten-free diet as been adhered to for a few weeks. Wheat-free products are not gluten-free as they may contain spelt, kamut, or barley. It is important to check food labels for gluten containing ingredients such as hydrolyzed plant and vegetable proteins, modified food starch, cereal solids, malt, malt extract, malt vinegar, bulgur, couscous, emmer, faro, kamut and semolina. Acceptable alternatives include arrowroot, amaranth, bean flours, buckwheat, flax, corn, millet, quinoa, rice, potatoes, sorghum, and tapioca. Non-wheat flours such as brown rice and amaranth contain more fat and protein and require refrigeration. When using refrigerated flours allow them the come to room temperature before measuring to assure accuracy. Constipation is a frequent complaint for patients following a gluten-free diet. Ways to increase fiber in the gluten-free diet may be by adding beans as side dishes or to salads; using whole-grain gluten-free flours such as garbanzo (21 gm), corn meal (10 gm) or amaranth (18 gm); and including high fiber fruits and vegetables to one's diet. Gluten – free commercial fiber supplements such as Benefiber, Metamucil and Citrucel, provide between 2-3 gm of fiber per tablespoon, which may also help with constipation. In the United States, the term "gluten-free" is unregulated. Recent legislation entitled "Food Allergen Labeling and Consumer Protection Act HR 3684 and S741" would require companies to list the top eight allergens (wheat, milk, eggs, fish, shellfish, tree nuts, peanuts and soybeans) on food labels as well as specific regulation for the term "gluten-free". If passed this would greatly aid patients with CD in purchasing safe food to eat. It is also important to know that

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medications may be affected as well as vitamin and mineral supplement. Helpful websites such as www.glutenfreedrugs.com and www.glutenfreediet.ca may aid professionals and patients in their quest for gluten-free products.

Six key elements in the prevention of symptoms and management of persons affected by Celiac disease:

Consultation with a registered dietitian
Education regarding the disease
Lifelong adherence to the Gluten-free diet
Identification and treatment of nutrition deficiencies
Access to an advocacy group
Continuous long-term monitoring by a multidisciplinary team

A skilled dietitian will be able to assist with balanced meal planning, finding sources of hidden gluten, addressing nutrition deficiencies and supplementation, identify additional food allergies or intolerances, shopping for gluten-free foods, as well as providing guidelines when eating in restaurants. Information received from a reliable source such as an experienced dietitian also may prevent patients from getting misinformation about celiac disease and the gluten-free diet that may further delay proper treatment. Another important factor in promoting celiac patient's success is access to support or advocacy groups. Organizations such Gluten Intolerance Group, www.gluten.net; Celiac Disease Foundation, www.celiac.org; and Celiac Sprue Association of the United States of America, www.csaceliacs.org, provide resource materials, product research and emotional and social support. Periodic check-up appointments with a multidisciplinary team may be required to encourage compliance, aid the patient with problem solving solutions and monitor for complications. Dietitians interested in learning more about celiac disease may join the practice group, The Dietitians in General Clinical Practice or contact DIGID@aol.com for more information and practical resources.

This article was reviewed by Charlotte Thessien, Manager, Clinical Dietetics—VA NWIHCS, Omaha Division

National Wear Red Day

On Friday, February 6, 2005, VA Medical Centers Bath and Canandaigua, New York, Rochester Outpatient Clinic, and Wellsville, Elmira Community Outpatient Clinic participated in the National Wear Red Day. Employees united in red attire to help raise awareness about the health issues of women and heart disease. Educational materials and storyboard heart displays were prominently displayed at each of sites in celebration of American Heart Month.

Employees at Rochester Outpatient Clinic

Employees at Bath VA Medical Center

Assessing Patients' Emotional and Spiritual Needs

by Paul Alexander Clark, Maxwell Drain, M.A., Mary P. Malone, M.S., J.D.

(Part 2 was featured in the January 2005 edition of HealthPOWER! Prevention News)

Prevalence of Emotional and Spiritual Needs. Problems such as depression, anxiety, and posttraumatic stress disorder occur frequently (20%–33%) among patients with cancer,[78,79] patients with advanced disease,[80] patients in the intensive care units (ICUs),[81] and general medical inpatients.[67] Moreover, levels of clinical depression severely underrepresent patients' experiences of negative emotions such as anger, fear, loneliness, sadness, and hopelessness.[82] The only study that has measured hospitalized patients' experiences of these emotions found that more than 70% of 1,124 discharged emergency cardiac patients reported experiencing problematic emotional reactions four months postdischarge.[83]

Even the most conservative estimates suggest that emotional distress almost always accompanies hospitalization. Hughes[84] found that depression arose among inpatients *before* any diagnosis, "apparently as a reaction to social stress." (p. 15) Scragg et al. [81] found that not only did 38% of patients in the ICU experience major symptoms of posttraumatic stress disorder but that "a proportion of the post-traumatic stress reported was directly attributable to the experience of treatment in the intensive care unit." (p. 9) In support of the notion of a more complex relationship between distress and trauma, a recent study has established that posttraumatic stress disorder symptoms do not simply increase with injury severity.[85] The fact that hospitalization can be preceded by severely distressing events, such as [86] trauma or medical diagnosis of a long-term illness, should further reinforce (and possibly compound) the saliency and prevalence of emotional distress during hospitalization.

According to national public opinion research, 79% of Americans believe that faith aids in recovery, and 56% believe that faith has helped them recover;[87] 87% of Americans consider religion to be "very important" or "somewhat important" in their life.[88] In another survey, 77% of hospital inpatients stated that physicians should consider patients' spiritual needs, and 48% wanted their physicians to pray with them.[89] Studies have found that religion and spirituality are used as common coping strategies,[90–92] with positive effects on emotional wellbeing sufficient to improve the patient's ability to cope with illness.[93–96]

Patients' Evaluations of Meeting of Emotional and Spiritual Needs. Analysis of 2001 Press Ganey National Inpatient data (*N* = 1,732,562) shows "the degree to which staff addressed emotional/spiritual needs" to be highly correlated (*r* =.75) with the overall patient satisfaction mean composite score. Emotional and spiritual needs rank second on the 2001 National Inpatient Priority Index (*Table 1)—as they have ranked every year since 1998. This analysis combines the performance measure (mean score) with relative importance to patients (correlation with overall mean score). These data demonstrate the following:

- Patients place a high value on their emotional and spiritual needs while in the hospital
- A strong relationship exists between the hospitals' care of patients' emotional and spiritual needs and overall patient satisfaction
- Care for patients' emotional and spiritual needs constitutes a significant opportunity for improvement for most hospitals

The existence of a strong relationship between overall patient satisfaction and emotional and spiritual needs confirms the results of previous studies. Ong et al.[97] found that oncologists' socioemotional behaviors affected cancer patients' visit-specific and global satisfaction. Gustafson et al.[98] found that information and emotional support needs were more important to patients than all other care delivery needs or service concerns. Greenley et al.[99] demonstrated lower patient satisfaction among persons with increased emotional distress. Bertakis et al.[100] observed a relationship between patient satisfaction and physicians' response to emotional needs. Burroughs et al.[101] found that "compassion with which care is provided" had the paramount effect on patients' intentions to recommend/return. Finally, Zifko-Baliga and Krampf[102] demonstrated that negative evaluations of emotional dimensions of

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care negatively affected evaluations of technical quality. These results all support the seminal theories of patient satisfaction as an emotional response to events[103] and the current understanding of patient satisfaction as a summation of all the patient's experiences in the hospital without distinction between service and technical care.[104]

Studies have found that religion and spirituality are used as common coping strategies, with positive effects on emotional wellbeing sufficient to improve the patient's ability to cope with illnesses.

Correlates of Patients' Evaluations of the Degree to Which Staff Addressed Emotional and Spiritual Needs. Analysis of the survey data (*Table 2) revealed that 3 of the 49 questions were highly correlated with the emotional and spiritual needs question: staff response to concerns/ complaints, staff effort to include patients in their treatment decisions, and staff sensitivity to the inconvenience that health problems and hospitalization can cause. Two other questions were moderately correlated. Linear regression analysis showed that a variety of variables did not predict patient perceptions of the "degree to which staff addressed emotional/spiritual needs" (*Table 3).

Discussion

Are Patients' Emotional and Spiritual Needs Important? The literature review provides strong evidence that emotional and spiritual needs affect health outcomes and hospital financial outcomes, and the survey reveals a strong relationship between the "degree to which staff addressed emotional/spiritual needs" and overall patient satisfaction. Care for patients' emotional and spiritual needs can therefore be considered a component of overall health care quality.

Are Hospitals Effective in Addressing These Needs? The results from the literature and the survey confirm that most patients experience some form of emotional distress or negative emotions and that hospitals do not wholly address these emotional and spiritual needs. A straightforward interpretation of these results depicts an emotionally and spiritually satisfying in-patient experience, as follows:

- Patients' and/or families' needs are handled in a timely, considerate, and empathetic way
- All tests, interventions, and treatments are explained in an emotionally sensitive and supportive decision-making process
- Staff demonstrably provide empathetic emotional support

Much research needs to be done to formulate a strong evidence base for the effects of specific emotional and spiritual care interventions on patient satisfaction. In the meantime, to address hospitals' needs for guidance on how to satisfy patients' emotional and spiritual needs, some suggestions will be proposed on the basis of the limited literature and from the experience of hospitals that have shown improvement in meeting those needs.

Fully meeting patients' emotional and spiritual needs involves a foundational infrastructure, which may include the provision of basic resources, persons to meet religious needs, an emotional and spiritual care quality improvement (QI) team, customized interventions, and a standardized elicitation of patients' emotional and spiritual needs. Response to patients' concerns/complaints, inclusion of patients in treatment decisions, and staff sensitivity to the inconvenience that health problems and hospitalization can cause can all serve as foci for improvement in emotional and spiritual care.

***Tables for this article will not be included in the newsletter. Please visit our website www.VAprevention.com to view related tables and/or this article in its entirety**

This article was reviewed by Hugh A. Maddry, Director, VA National Chaplain Service, Hampton, VA

Part 4 of this article will conclude in the May 2005 Health*POWER*! Prevention News

One-Stop Healthcare For Homeless Mentally Ill Veterans

Jessica Blue-Howells, MSW
VA Greater Los Angeles Health Care System

Ron S, a formerly homeless veteran on the services of the Center Primary Care Clinic: "My cholesterol was high. My primary care nurse practitioner helped me come up with alternatives to lower it. She suggested changing diet, using the wellness center, and trying meds if I needed it. She got me connected with a dietician, and I made a Thanksgiving pact with the dietician: Only one slice of pie this year. I felt included in planning my diet changes and I felt like I had choices of where to start. At my last check, my cholesterol's down 5 points!"

In 1999, the homeless staff in the VAMC at West Los Angeles were concerned that homeless veterans were not getting access to outpatient medical care services, and were using the VA for social services only. While veterans qualified to receive care at the VA, barriers to care were many – foremost among them that appointments for physical exams were scheduled six to eight weeks in the future and veterans didn't return for their appointments. We realized that if we implemented a one-stop model that catered to the needs of homeless veterans, the veterans would be much more likely to actually use primary care services – thus improving their acute and chronic disease management and increasing receipt of preventive services.

To get the new clinic started, we applied for VA Central Office New Clinical Initiatives funding, and we were awarded funding in 2001 for a project called "Primary Care Program For Homeless And At Risk Veterans" (#NPI-00-022-1). The program model co-located homeless social services with primary care and mental health services in one building. In July 2002, we opened the doors of our new, multi-service clinic, the Mental Health Outpatient Treatment Center. We created a Screening Clinic staffed by nurses and social workers as the access point into Center services. While there have been other demonstrations of integrated mental health-primary care (Druss et al., 2001) and substance abuse-primary care (Freidman et al., 2003) programs, this is the only Center of its kind being implemented and evaluated in VHA.

The delivery of care model begins with community outreach by Center staff. Upon arrival at the Center, homeless veterans are greeted and oriented to care by staff who are formerly homeless veterans. Veterans are assessed by an RN, who determines whether they have emergent, urgent or routine needs, and are then linked appropriately to care within the Center or transported to Medical Center emergency care. Center staff are able to make direct, and in many cases same-day, referrals to homeless, primary care and mental health staff for services.

Services available in our Center include:

- Screening: eligibility confirmation, nurse assessments, psychiatry screening, care coordination and linkage to services.
- Comprehensive Homeless Center: referrals for emergency housing, transitional housing, substance abuse services, benefits counseling and vocational rehabilitation. The center also provides lunch, showers, clean clothing and transportation assistance.
- Primary Care Clinic: same day physical exams, scheduled and walk-in follow-up care (depending on the veterans' preference), lab services, basic medications and coordination with specialty care services.
- Mental Health Clinic: same day assessments and clinic enrollment, medication management, group and individual counseling and psychological testing.

To date, aspects of successful implementation of the Project in helping homeless veterans gain access to and continued engagement in clinical care are:

- Numbers served and entry into care: On average, each month 640 homeless and mentally ill veterans safely use the Screening Clinic, and 470 patients are being seen at the Primary Care Clinic. July-December 2004

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data indicate that:

- 22% of veterans using the Center needed primary care, and 82% of these veterans were seen the same day.
- 24% of veterans using the Center needed mental health services, and 78% of those veterans were seen the same day by a psychiatrist or other mental health professional.

- Quality of primary care prevention services: Our Primary Care Clinic excels in completing clinical reminders for a very difficult to serve veteran population. Recent aggregate rates of completion in the homeless primary care clinic are:

Overall receipt of appropriate preventive services: 84%

  - Depression Screening: 97%
  - Alcohol Screening: 92%
  - Colorectal Cancer Prevention: 67%
  - Hemoglobin A1C: 96%
  - Prostate Cancer Counseling: 77%
  - Diabetes Foot Exam: 83%
  - Pneumovax: 78%
  - Diabetes Eye Exam: 63%
  - Influenza Immunization: 72%
  - Hepatitis C Risk Assessment: 82%
  - Tobacco Use Screening: 91%
  - HTN Lifestyle Education: 68%
  - Healthwise Book: 81%

What is striking about homeless veteran patients receiving 84% of appropriate primary care services is that in a study of a comparison sample seen in regular primary care prior to the opening of the co-located clinic, homeless veterans received only 43% of overall appropriate primary care preventive services (McGuire et al., 2005).

- Health Education: A new addition to our services is Health Education classes that are taught to homeless veterans. We have two modules, physical health and mental health. We are developing a plan to evaluate the impact on use of primary care and mental health care services. The modules are:
  - Physical Health: Tips to Understand and Access Healthcare, Heart Health, Nutrition, Physical Activity and Stress
  - Mental Health: How to Access Mental Health Services, Anxiety, Depression, Coping Skills and Problem Solving
- Homeless veteran satisfaction with primary care services: A Summer 2003 study of 77 homeless veterans utilizing the Primary Care Clinic found that 81% viewed the Clinic as "very organized", 82% reported that the main reason for their visit to the clinic was "completely" addressed to their satisfaction and, 85% reported the overall quality of visit was "very good" or "excellent".

We are conducting a formal program evaluation with multiple components including aggregate and longitudinal assessment of patient care and outcomes, assessment of staff and services integration, and project implementation process evaluation. The comparison of medical, psychiatric, and social outcomes of 130 veterans receiving "usual primary care" prior to the opening of the Center and 130 veterans recruited following the opening of the Center who have received "co-located care" will be available in 2006.

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This article was submitted by James F. McGuire, PhD
NEPEC Director, Greater Los Angeles Health Care System

Making a Difference in the Year 2005
Prevention Champion (Clinical, Administrative, Team)

*The VA National Center for Health Promotion and Disease Prevention is pleased to announce the quarterly **National Prevention Champion Award,** which will be presented to one VA employee per quarter, per category, in recognition of meritorious and distinguished accomplishments in the field of Prevention and Health Promotion in the Veterans Health Administration*

Please write a brief description (limit narrative to 1-2 pages and address achievements within the past 12 months) regarding your nomination (on reverse side/blank sheet). Justification factors you may consider:

- Someone who has made significant contributions in the field of health promotion and disease prevention (clinical, education, research)
- Someone who has done an excellent job in a function or on a project related to prevention/health promotion
- Someone who has taken initiative, shown innovativeness, persistence, has an impact and/or made a difference in prevention/health promotion to veterans served
- Someone you feel worthy of such an award, maybe a leader, a helper, a shaker and a mover who makes the impossible happen
- Team awards will be considered

Making a Difference in the Year 2005
Team Employee Wellness Champion

*The VA National Center for Health Promotion and Disease Prevention is pleased to announce the quarterly **Team Employee Wellness Champion Award,** which will be presented to one VA team per quarter in recognition of meritorious and distinguished accomplishments in the field of Employee Wellness in the Veterans Health Administration*

Please write a brief description (limit narrative to 1-2 pages and address achievements within the past 12 months) regarding your nomination (on reverse side/blank sheet). Justification factors you may consider:

- Someone who has made significant contributions in the field of employee wellness
- Someone who has done an excellent job in a function or on a project related to employee wellness
- Someone who has taken initiative, shown innovativeness, persistence, has an impact and/or made a difference in employee wellness to VA staff served
- Someone you feel worthy of such an award, maybe a leader, a helper, a shaker and a mover who makes the impossible happen
- Only teams will be considered for this award

Making a Difference in the Year 2005
Silver Star Award (to be submitted by winners of the Prevention Champion Award ONLY)

*The VA National Center for Health Promotion and Disease Prevention is pleased to announce the quarterly **Silver Star Award,** which will be presented to one individual (meeting the criteria listed below) **named by each Prevention Champion** selected (Clinical, Administrative, Team) per quarter in recognition of their encouragement and support of the Prevention Champions in the Veterans Health Administration*

Prevention Champion winners will be asked to indicate the name of the higher-level individual who has been instrumental in helping that person achieve the status of Prevention Champion. Justification factors to consider:

- Someone who has made a difference to you
- Someone who has facilitated career growth
- Someone who has encouraged the individual to be a prevention champion
- Someone deemed worthy of such an award, a shaker and a mover who makes the impossible happen
- This individual may function in an administrative, supervisory, teaching or mentoring capacity

2005 Award Nomination Form
(Prevention Champion, Team Employee Wellness, Silver Star)

☐ **Prevention Champion** ☐ **Employee Wellness (Team)**

- ☐ **Clinical***
- ☐ **Administrative***
- ☐ **Team**

***Winners will select Silver Star recipients**

Name of Nominee: _____

Where Employed: _____
Service, Department, Unit Work Phone # Email Address

Facility Name/Number: _____
Facility Name Facility Number

The winners will receive:

****A Special Award**Recognition in the Health*POWER*! Prevention News **Recognition at the Next Prevention Conference**Recognition on the NCP Website Showcasing Accomplishments****

1st Quarter
Submission deadline: December 15, 2004
Award announcement: January 15, 2005

2nd Quarter
Submission deadline: March 15, 2005
Award announcement: April 15, 2005

3rd Quarter
Submission deadline: June 15, 2005
Award Announcement: July 15, 2005

4th Quarter
Submission deadline: September 15, 2005
Award announcement: October 15, 2005

You may submit nomination forms via:
Website: www.VAprevention.com
E-mail: rosemary.strickland@med.va.gov
Fax: 919-383-7598
Mail: NCP
Attn: Rosemary Strickland
3022 Croasdaile Drive, Suite 200
Durham, NC 27705
Questions? Please call 919-383-7874
Ext. 233 (Connie) or Ext. 239 (Rosemary)

MARK YOUR CALENDAR! May 18, 2005
MOVEmployee! Health & Fitness Day

Join the Wellness Walk & Roll during lunchtime at your VA medical facility. Additional activities may be offered to encourage healthy eating and physical activity in support of *MOVEmployee!* Health & Fitness Day. If your job duties or shift schedule do not allow you to participate in the Wellness Walk & Roll, you may still participate in spirit and action with a Prevention Pledge.

Check with your Wellness Coordinator for more information.

VA National Center for Health Promotion
and Disease Prevention
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Durham, NC 27705

Putting Prevention Into Practice in the VA